fallon community health plan, inc.

schedule of benefits 2200

This *Schedule of Benefits* is part of your
Commonwealth of Massachusetts
FCHP Select Care Member Handbook.
It describes your costs for health care.

copayments

This plan includes three different office visit copayments. The amount of the office visit copayment you pay depends on the tiering level of the plan physician you visit.

Tier 1* (Excellent)**: Plan physicians practicing at an excellent level of quality and cost efficiency.
Tier 2 (Good)**: Plan physicians practicing at a good level of quality and cost efficiency.
Tier 3* (Standard): Plan physicians practicing at a standard level of quality and cost efficiency.

- You have a $10 (Tier 1), $15 (Tier 2) or $25 (Tier 3) copayment for office visits with your PCP.
- You have a $15 (Tier 1), $25 (Tier 2) or $35 (Tiers) copayment for office visits with specialty physicians.
- You have a $15 copay for office visits with the following plan specialists:
  - mental health and substance abuse providers
  - chiropractors
  - physical and occupational therapists
  - speech-language pathologists and audiologists
  - early intervention specialists
  - certified nurse midwives
  - nurse practitioners who bill independently

- optometrists (for routine eye exams only)

This plan includes a limit to the copayments you pay for inpatient admission copayments and outpatient surgery copayments. You are responsible for a maximum of four inpatient admission copayments and a maximum of four outpatient surgery copayments per year.

This plan includes an out-of-pocket maximum for mental health outpatient copayments. You are responsible for an out-of-pocket maximum of $1,000 per member/ $2,000 per family in each year.

This plan includes an out-of pocket maximum for substance abuse outpatient copayments. You are responsible for an out-of-pocket maximum of $1,000 per member/ $2,000 per family in each year.

Services that require plan preauthorization

The following covered services require preauthorization from the plan. Preauthorization must be requested by your PCP, or in some cases, your specialist.

- All elective admissions to a hospital or other inpatient facility
- Services with a non-FCHP Select Care network provider
- Organ transplant evaluation and services
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Pain clinic
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health care and hospice care

- Nonemergency ambulance

The following chart shows your costs for covered services. These costs apply to the services in the **description of benefits** section of your *Commonwealth of Massachusetts FCHP Select Care Member Handbook*. In summary, your responsibilities are as follows:

covered services	benefit
ambulance services	
1. Ambulance transportation for an emergency	Covered in full
2. Ambulance transportation for preauthorized nonemergency transfers	Covered in full
durable medical equipment and prosthetic/orthotic devices *Referral and plan authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance)	20% coinsurance
2. Hearing aid(s). (Benefit available once every two years.)	The first $500 of the purchase price is covered in full; you pay 20% of the next $1,500 of the purchase price plus all additional costs, to a maximum purchase price of $2,000.
3. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.	20% coinsurance

covered services	benefit
durable medical equipment and prosthetic/orthotic devices, continued	
4. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	Covered in full
5. Oxygen and related equipment	20% coinsurance
6. Insulin pump and insulin pump supplies	Covered in full
emergency and urgent care	
1. Emergency room visits	$75 copayment per office visit
2. Emergency room visits when you are admitted to an observation room	Covered in full
3. Emergency room visits when you are admitted as an inpatient	Covered in full
4. Urgent care visits in a doctor's office or at an urgent care facility	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
5. Emergency prescription medication provided out of the FCHP Select Care service area as part of an approved emergency treatment	Tier 1: $10 copayment Tier 2: $25 copayment Tier 3: $40 copayment for up to a 14-day supply

covered services	benefit
home health care services *Plan authorization required*	
1. Skilled nursing care	Covered in full
2. Physical, occupational and speech therapy	Covered in full
3. Medical social services	Covered in full
4. Home health aide services	Covered in full
5. Medical and surgical supplies and durable medical equipment	Covered in full
6. Nutritional consultation	Covered in full
7. Certain injectable medications that are administered in the home setting, when approved by FCHP and received through a plan-approved pharmacy vendor	Tier 1: $10 copayment Tier 2: $25 copayment Tier 3: $40 copayment for up to a 30-day supply
hospice care *Referral and plan authorization required*	
1. Nursing care provided by or under the supervision of a registered professional nurse (includes services provided by a home health aide)	Covered in full
2. Medical social services provided by a social worker	Covered in full
3. Outpatient physicians' services provided by a doctor of medicine or doctor of osteopathy	Covered in full

covered services	benefit
hospice care, continued	
4. Counseling services, such as dietary or bereavement, provided to the terminally ill individual and the family members or other persons caring for the individual at home	Covered in full
5. Short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting	$250 copayment per admission to hospital Covered in full if admitted to hospice or skilled nursing facility
6. Medical appliances and supplies	Covered in full
7. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills	Covered in full
8. Prescription medication that is related to the terminal illness of the individual	Tier 1: $10 copayment Tier 2: $25 copayment Tier 3: $40 copayment for up to a 30-day supply

covered services	benefit
hospital inpatient services *Referral and plan authorization required*	
1. Room and board in a semiprivate room or a private room when medically necessary	$250 copayment per admission
2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include but are not limited to diagnostic lab, pathology and X-ray services, anesthesia services, short-term rehabilitation, and operating and recovery room services	Covered in full
3. Physician and surgeon services	Covered in full
4. General nursing services	Covered in full
5. Intensive and/or coronary care	Covered in full
6. Dialysis services	Covered in full
7. Medical, surgical or psychiatric services	Covered in full
8. Nursing services provided by a certified registered nurse anesthetist	Covered in full

covered services	benefit
infertility/assisted reproductive technology (art) services* *Referral and plan authorization required (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
2. Diagnostic laboratory and X-ray services	Covered in full
3. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full
4. Assisted reproductive technologies*	Covered in full
5. Sperm, egg, and/or inseminated egg procurement, processing and banking, to the extent that such costs are not covered by the donor's insurer	Covered in full
* See the **description of benefits** section of your *Member Handbook/Evidence of Coverage* for a list of covered infertility/ART services.	

covered services	benefit
maternity services	
1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal: Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $25 copayment first visit only Postnatal: Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: 25 copayment per office visit
2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified	$250 copayment per admission

covered services	benefit
maternity services, continued nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider.	
3. Charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth	Covered in full
mental health care **inpatient services** *Plan authorization required*	
1. Room and board in a semiprivate room (or a private room when medically necessary) for respite, short-term residential, and hospital care only	Covered in full
2. The treatments and supplies that would ordinarily be furnished to you while you are an inpatient. These include but are not limited to individual, family and group therapies, pharmacotherapy, and diagnostic laboratory services.	Covered in full
3. Professional services provided by physicians or other licensed mental health professionals for the treatment of psychiatric conditions	Covered in full

covered services	benefit
mental health care **intermediate services** *Plan authorization required*	
1. Diversionary services such as day treatment/evening treatment and/or partial hospitalization for a full or partial day. Any of these services require authorization from the plan	Covered in full
outpatient services	
1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy.	$15 copayment per office visit
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	$15 copayment per office visit
3. Neuropsychological assessment services when medically necessary	$15 copayment per office visit

covered services	benefit
office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	PCP: Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit Specialist: Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
2. A second opinion, upon your request, with another plan provider	PCP: Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit Specialist: Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
3. Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider	Covered in full

covered services	benefit
office visits and outpatient services, continued	
4. Allergy injections	Covered in full
5. Radiation therapy	Covered in full
6. Respiratory therapy	Covered in full
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
8. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.	$15 copayment per office visit
9. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full
10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 20 office visits in each calendar year. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan.	$15 copayment per office visit
11. Outpatient renal dialysis or continuous ambulatory peritoneal dialysis	Covered in full

covered services	benefit
office visits and outpatient services, continued	
12. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
13. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full
14. Medical social services provided to assist you in adjustment to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
15. Voluntary family planning services, including: • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods; reproductive health education and disease prevention; genetic counseling; and elective sterilization	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit

covered services	benefit
office visits and outpatient services, continued	
• Contraceptive devices that are supplied by an FCHP Select Care provider during an office visit • Termination of pregnancy in an office setting (Note: Termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)	
16. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	$125 copayment per surgery

covered services	benefit
oral surgery and related services *Referral and plan authorization required (except for extraction of impacted teeth)*	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
5. Lingual frenectomy	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit

covered services	benefit
oral surgery and related services, continued	
6. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to the sound natural teeth or tissues when provided as soon as medically possible after injury. This does not include restorative or other dental care. You do not need authorization for emergency care. Go to the closest provider. Note: See **office visits and outpatient services** for diagnostic lab and X-ray services.	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
organ transplants *Referral and plan authorization required*	
1. Office visits related to the transplant	Tier 1: $15 copayment per visit Tier 2: $25 copayment per visit Tier 3: $35 copayment per visit
2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient*	$250 copayment per admission
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services	Covered in full

covered services	benefit
organ transplants, continued	
4. Human leukocyte antigen (HLA) or histocompatability locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Covered in full
prescription drugs **Covered prescription items:** • Prescription medication • Contraceptive drugs and devices • Hormone replacement therapy • Injectable agents (self-administered*) • Insulin • Syringes or needles (including insulin syringes) when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • Certain injectable medications administered in the home setting, when approved by FCHP and received through a plan-approved pharmacy vendor * Injectables administered in the doctor's office or under other professional supervision are generally covered as a medical benefit.	**Network pharmacy:** Tier 1: $10 copayment Tier 2: $25 copayment Tier 3: $40 copayment for up to a 30-day supply **Mail-order pharmacy:** Tier 1: $20 copayment Tier 2: $50 copayment Tier 3: $90 copayment for up to a 90-day supply

covered services	benefit
preventive care	
1. Routine physical exams for the prevention and detection of disease	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
2. Immunizations that are included on the FCHP formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
5. Routine eye exams, once in each 24-month period	$15 copayment per office visit
6. Hearing and vision screening	Covered in full

covered services	benefit
preventive care, continued	
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment	Tier 1: Covered in full Tier 2: $5 copayment per visit Tier 3: $10 copayment per visit
8. Pediatric services including: • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening	Tier 1: Covered in full Tier 2: $5 copayment per visit Tier 3: $10 copayment per visit
9. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit

covered services	benefit
preventive care, continued	
10. Contraceptive devices that are supplied by an FCHP Select Care network provider during an office visit* * Prescription contraceptive devices are covered under the prescription drug benefit.	Tier 1: $10 copayment per visit Tier 2: $15 copayment per visit Tier 3: $25 copayment per visit
11. Coronary artery disease secondary prevention program for members with a history of heart disease. This is a program that helps you reduce your heart disease factors through lifestyle changes. Members completing the program are eligible for a $100 reimbursement of the copayment amount. Contact Customer Service for more information.	$250 copayment
reconstructive surgery *Referral and plan authorization required (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic PCP)*	
1. Reconstructive surgery to repair a condition resulting from injury, birth defect or noncosmetic surgery	$125 copayment per outpatient surgery $250 copayment per inpatient admission
2. Removal of breast implants due to complications of noncosmetic surgery or autoimmune disease	$125 copayment per outpatient surgery $250 copayment per inpatient admission

covered services	benefit
reconstructive surgery, continued	
3. Reconstructive surgery for postmastectomy patients as follows: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prosthesis and any physical complications resulting from the mastectomy, including lymphedema	Covered in full
rehabilitation services *Referral and plan authorization required*	
1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit. Visits after 90 days require prior authorization.	$15 copayment
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit.	$15 copayment
3. Respiratory therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit.	$15 copayment

covered services	benefit
rehabilitation services, continued	
4. Treatment for acute episodes of an illness related to a chronic condition when the benefit limit has not been exceeded	$15 copayment
5. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by an FCHP Select Care provider who is a speech-language pathologist or audiologist; and at an FCHP Select Care provider facility or FCHP Select Care provider's office.	$15 copayment
6. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full
7. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday. Benefits are limited to a maximum of $5,200 per calendar year per child and an aggregate benefit of $15,600 over the term of the child's plan membership.	Covered in full

covered services	benefit
skilled nursing facility services *Referral and plan authorization required*	
1. Room and board in a semiprivate room (or private room if medically necessary), for up to 100 days in each calendar year, provided criteria is met	Covered in full
2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment	Covered in full
3. Physician services	Covered in full

covered services	benefit
special formulas *Referral and plan authorization required*	
1. Special medical formulas to treat certain metabolic disorders as required by state law. Metabolic disorders covered under state law include: phenylketonuria, tyrosinemia; homocystinuria; maple syrup urine disease; propionic academia; and methylmalonic academia in a dependent child, including when medically necessary to protect unborn fetuses of pregnant women with phenylketonuria.	Covered in full
2. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids	Covered in full
3. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. Coverage is provided for up to $2,500 per member in each calendar year. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full

covered services	benefit
substance abuse services Note: No limits apply when substance abuse services are provided in conjunction with the treatment of mental disorders.	
inpatient services *Authorization required*	
1. Detoxification services for as many days as are required, based on medical necessity	Covered in full
2. Rehabilitation services for alcoholism for up to a maximum of 30 days in each calendar year (this limit does not apply when treatment is also for a mental disorder)	Covered in full
3. Rehabilitation services in a day-treatment setting	Covered in full
4. Room and board in a semiprivate room (or private room if medically necessary)	Covered in full
5. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, group and family therapies and diagnostic/laboratory services.	Covered in full
6. Physician services such as medical and rehabilitation services for the treatment of alcohol or drug abuse	Covered in full

covered services	benefit
substance abuse services **intermediate services** *Plan authorization required* 1. Diversionary services such as crisis intervention, day treatment/evening treatment, acute residential or other treatment as appropriate. Any of these services require authorization from the plan.	Covered in full
outpatient services 1. Outpatient office visits to treat the abuse of, or addiction to, alcohol and drugs. The actual number of visits authorized is determined by medical necessity, and may include individual, group and family therapies.	$15 copayment per office visit